Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	000448	A. BUILDING: _____ B. WING _____	06/06/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERCREST CHURCH OF BRETHREN	2201 EAST ST NORTH MANCHESTER, IN 46962

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	INITIAL COMMENTS This visit was for a State Licensure Residential Survey. Survey Dates: June 2, 3, 4, 5, and 6, 2014 Facility Number: 00448 Provider Number: 00448 AIM Number: N/A Survey Team: Kim Davis, RN,TC Shelly Reed, RN (June 3, and 4, 2014) Census Bed Type: Residential : 188 Census Payor Type: Other: 188 Total: 188 Sample: 10 Timbercrest Church of the Brethren was found to be in compliance with 410 IAC 16.2-5. Quality review completed by Debora Barth, RN.	R 000		

Indiana State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE